A PRACTICING PHYSICIAN'S EXPERIENCE*

ELIZABETH A. GOESSEL, M.D.
Associate Attending Physician
Lenox Hill Hospital
Medical Department
Chase Manhattan Bank
New York, New York

FOR THIS AUDIENCE I need neither review nor detail government programs to curtail the costs of medical care or to institute quality control. Suffice it to say that these programs have forced the closing of many hospital beds and have mounted a vast campaign to reduce utilization and to cut physicians' fees. They accuse the profession of over-utilization of services at a time when the legal profession has launched a witch-hunt into every alleged deviation from quality. The profession's age-old tradition to monitor its own members and to uphold quality was neither helped nor updated, it was largely dismissed. Malpractice insurance premiums have forced many specialists to close their doors. There are no longer fifteen to twenty applicants for every place in medical school but fewer than two, and not the best or the brightest, some say. My short remarks are simply to share what it is like to care for patients during these times.

Practicing medicine carries privileges but also awesome responsibilities. We are privileged to ask the most personal questions of a total stranger and then to examine that most private of all possessions, the human body. With this information, plus findings from appropriate tests, we must decide whether the person has an illness and if so, the nature of that illness, and having determined that, decide upon the best way to restore that person to a state of health. It sounds perfectly easy. It is not. The welfare of that patient—indeed his life—is in our care. That is what I mean by an awesome responsibility. And a sacred trust.

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Address for reprint requests: 737 Park Avenue, New York, N.Y. 11021

While much of the basic science of medicine remains the same, more and more of the complexities of the human mind and body are still being unravelled. On this ever-changing and expanding infrastructure is superimposed the "art" of medicine, the skill with which a physician uses the available resources and technologies as well as the patient's own belief system to achieve the desired goal, namely, restored health.

More and more evidence documents that the patient's mental attitude profoundly affects the outcome. And so does the attitude of the physician.

Most of us are aware of these subtleties in the patient-physician relationship. Let me share a few experiences of interference with this relationship, experiences not only of my own but also of my colleagues. Imagine what happens when a patient receives from Medicare the following so-called "Explanation of Medicare Benefits": "You are responsible for the difference between the billed amount and Medicare's payment. You could have avoided paying the difference between the billed and approved amounts for all covered services if the claim had been assigned.—Participating doctors and suppliers always accept assignment of medicare claims. See the back of this notice for an explanation of assignment. Write or call us for the name of a participating doctor or supplier or for a free list of participating doctors and suppliers." These messages go to patients financially able to pay the few dollars difference between what Medicare allows the physician to charge for the service and what they will pay for that service. Patients who cannot afford the difference are already on assignment.

It has been well documented that when patients are responsible for a copayment, as is the case of nonassigned patients, demand for services decreases. By offering "free" medical care, the government is simply asking for patients to demand more services. That is hardly a way to save money.

Personally, I have grave doubts about the legality of interfering with the patient's right to choose his physician and the physician's right to earn a living by practicing his profession in an honorable way. I have been told that this is a violation of Federal Trade Commission laws.

Share with me the following experiences of taking care of patients. Think of them perhaps as someone near and dear to you.

A patient who has suffered a heart attack is taken to an emergency room where he spends the next 36 hours hooked up to a monitor that nobody is watching in the midst of the din and clatter that characterize emergency rooms.

A 78-year-old woman with severe abdominal pain spends five hours in the waiting area of the emergency room and cannot be seen by a physician

because there is no space for her. She goes home without being seen, returns in the middle of the night, in extremis, and is admitted to the emergency room where she spends the next 24 hours waiting for a bed.

A diabetic patient with heart disease and kidney disease has a massive heart attack, suffers cardiac arrest, is resuscitated and leaves the hospital alive. His doctor is asked by Medicare to write a letter of explanation to justify the admission.

A patient with maxillary sinus cancer develops septicemia, survives that, develops renal failure, survives that, and finally leaves the hospital alive. Of his 57-day stay, 37 days were spent in the intensive care unit. The Diagnosis Related Group allows 12 days for a "disease of the ear, nose and throat."

An 87-year-old patient with cataracts is denied permission to have cataract surgery as an inpatient even though he lives alone, is legally blind, and cannot care for himself during the postoperative period. This is deemed a "social problem" and Medicare does not pay for "social problems."

I wish that I could tell you that these anecdotes are, if frustrating, rare. They are not. They are practicing physicians' daily fare. They are part of the Kafka-esque nightmare in which we practice medicine today. How, you might ask, did we ever get to this absurd state of affairs?

Speaking of absurdities, a patient receives a lengthy notification that the physician's charge of one cent is "not covered by Medicare." This is, of course, a computer glitch and not due to a grasping and penny-pinching doctor. The form was resubmitted. These episodes waste office staff time but they do afford occasional comic relief.

Our current critical shortage of beds was based on government assertions that closing down beds would reduce the cost of medical care. That did not happen. It has simply caused a back-up and crowding of ill or injured patients who must be cared for.

In a similar move, chronic disease hospitals were closed but nobody eliminated chronic diseases. Those patients now linger in acute care hospital beds awaiting placement in nursing homes. This is because of the battle between the state and the federal governments: as long as the patient is in an acute care bed, the federal government pays the bill. When the patient is moved to a nursing home, state-administered federal money pays the bill.

It is not only emergency rooms that are in disarray. The nursing stations in our hospitals look like disaster areas. It is surprising that there are not more accidents. There is, on average, one nurse for every eight patients and one nurse cannot care for eight sick people. Patients now admitted are sicker and older than ever before.

The shortage of nurses is worldwide. We are importing nurses from around the world, but that is a stopgap measure and eventually the supply will run out. Working conditions for nurses are appalling. They work long hours under battle conditions and with none of the job satisfaction that they once enjoyed. Esprit and morale are nonexistent. There is little incentive for young women to embark on a career in nursing. Other fields offer higher pay and better working conditions.

Like closing hospital beds, the DRG is another governmental device designed to control utilization. This diagnosis related group payment has so skewed what has happened to the patient that one can only call it silly. I have already mentioned the cancer patient with the lengthy intensive care unit stay who was "allowed" only 12 days.

Today a young person will think twice about the enormous expenditure of time and money to become a physician only to be so regulated that he will never be able to give the kind of care that patients require. The quality of medical care in this country will most certainly deteriorate under the present circumstances.

Because of the difficulties of dealing with the Medicare system, more and more physicians refuse to see patients older than 60. This limits the availability of physicians to older patients. Here again is another infringement of the patient's right and, again, the older population is being disenfranchised.

Is it any wonder that we spend 11% of our gross national product on medical care, the highest of any industrialized country? The fact is that we are not getting medical care for that money. What we are getting is an overwhelming regulatory bureaucracy that is adversarial, that consistently interferes with the delicately balanced patient-physician relationship, with the right of our older citizens to choose their physicians, and, indeed, with their right to be treated at all when they are ill. As you know, any adversarial system invites both sides to try to circumvent the system. The victim in any case is the patient.

The propaganda to lure patients away from their physicians, to engender doubt and distrust, and a system designed to heap mountains of paper on both patient and physician do nothing but create chaos and confusion. What amounts to mischievous meddling does not save one cent of the medical care dollar but simply burdens the system with more expenses. It is an irresponsible answer to a serious problem.

To a great extent that problem is engendered by poverty...unless, of course, one makes poverty secondary to greed, avarice, ignorance, and paralysis of leadership.

Poverty results in the expenditure of $190 million dollars a year in New York City alone to care for infants born to drug-addicted or AIDS-infected mothers. These infants are born with low birth weight and/or multiple congenital anomalies requiring expensive surgery and lengthy hospital stays in pediatric intensive care units and then are abandoned to become permanent residents of our hospitals. $190 million dollars would buy a great deal of prenatal care, drug detoxification programs, and drug and sex education. It should cost much less to prevent these tragedies than to cope with them after they have occurred. Estimates are that every dollar spent on prevention, depending on which problem is attacked, saves between five and 10 dollars.

The death rate for newborns in this country is the highest in the industrialized world. Infant mortality is higher in this country than it is in Singapore. Washington, D.C., with a death rate of 21 for every 1,000 live births, is the worst in the nation.

It is poverty that persuades a mother of five or six hungry children to look the other way when one child goes on the street to sell drugs to feed the family. What if that child is caught and incarcerated—or even killed? Better to risk one than to have all live in degrading poverty.

It is poverty that has countless thousands of men, women, and children living on the streets of our cities and towns and even in rural areas. Some of these unfortunates were released from mental institutions to be returned to a caring "community"—a community that does not exist. And it is planned that an additional 1,700 will be "deinstitutionalized" within the next year to take up residence on the sidewalks, in rail and bus terminals, in alleyways, in the subway stations and on the subways. By creating this large population of the homeless, we are creating a pool of disease-prone human beings who will live and die on the streets. These people will never collect Social Security, nor will they collect welfare checks nor Medicare nor Medicaid. This genocide will save federal, state, and city governments billions of dollars and make this country the scene of another holocaust.

Poverty and drugs go hand-in-hand. Another population is growing rapidly—the abused and tortured children of crack-addicted mothers. These children, who have known only abuse and no love or affection or kindness, adopt the behavior patterns of frenzied animals. Agencies responsible for their placement cannot find homes for them because they are simply too fierce—as small children. What do you think they will be doing five and 10 years from now, if they live that long?

Most human social tragedies that arise from poverty, drug and alcohol abuse, ignorance, and illiteracy end up on the doorstep of medicine. What

will happen when the ravages of AIDS are added with no preparation whatsoever? No longer the province of rejected minorities, the fastest growing segment of the AIDS population is women. Is it any wonder that we shall spend $620 *billion* dollars on health care in 1989?

A decade ago, as medical director of the New York County Health Services Review Organization, I had the opportunity to review the figures on exactly what the federal health care dollar was buying. Reviewing thousands of admissions, I found that most of the money was spent on drug and alcohol abuse or drug and alcohol-related diseases. A decade later the situation is worse. Crack was not a problem 10 years ago. It is now the leading industry of the ghetto and will continue so unless it is decriminalized and made a matter for health and education. The billions of dollars involved in this illicit industry corrupt all it touches, from the heads of states down through every level of the political and enforcement communities. And billions of dollars still flow out of this country into the hands of the most despicable members of the human species.

Our society must recognize that the distinction between drugs and alcohol is specious as far as health is concerned. To separate them is to promote confusion. There are 18 million alcoholics and six million drug-dependent individuals in our society. To spotlight the problems of the six million is to deny the problems of the 18 million. One in every three families is affected by the tragedies that result. Today in New York City 60% of all emergency room visits to city hospitals are crack-related.

If we continue to avoid social planning for the poor, the drug and alcohol-addicted—if we continue to watch the decay of our educational system—if we continue to ignore prenatal care and appropriate institutions for the aging—if we continue to poison our air, water, and soil we can certainly continue to expect ever greater health care costs and an increasing sense of futility in the practice of medicine.

As long as our society is powered by greed and avarice and the mindless determination to continue to produce nuclear weapons when there are already enough of them to blow up this planet 100 times over, we can expect no relief from the downward direction we are now taking.

Our medical care system as it presently exists is not prepared to meet the overwhelming challenges that tomorrow will most certainly bring. We have mentioned a few: AIDS, aging, drugs, and alcohol.

Good medical care must be made available for everyone and supported by a sound plan of insurance and a sensible plan of administration. Control of utilization and quality is simply a part of the ongoing medical education of

every physician. Nobody objects to high quality and high standards but the responsibility for this must, eventually, be returned to the physicians who can organize that control if they work closely together in groups.

Radical, you ask?

I am echoing the recommendations of the forward-looking members of the "Committee on the Costs of Medical Care" of 60 years ago. When will we learn? How much longer must we wait?